RI Department of Human Services, Early Intervention Program

Services Rendered Form

ID: _____ **Last Name:** _____ **First Name:** _____ **MI:** _____

DOB: _____ **Service Coordinator:** _____ **Insurance Coverage Change:** ☐ **Yes** ☐ **No**

Service Date:

Cancellation:

- ☐ **No Show**
- ☐ **Cancel**
- ☐ **Provider Cancel**

Visit Participants:

Service Location:

- ☐ Home
- ☐ Community Setting
- ☐ Telephone Call
- ☐ Daycare
- ☐ EI Center
- ☐ Hospital impatient
- ☐ Residential Facility
- ☐ Service Provider Location

Program Design:

- ☐ For children with developmental delay
- ☐ For typically developing children

Natural Environment:

☐ Yes ☐ No

Family/Caregiver Update: what has happened since our last visit? Please print clearly

Outcomes Addressed:

Observations/Strategies/Notes

Suggestions for follow up during daily routine

Provider/Signature	**Service Codes: Minutes:**	**NEXT VISIT:**	**TIME:**
1.			
Date		**Signature parent/Guardian**	**Date**
2.			
Date		**Parent/Guardian – initial # EI provided Transportation**	
3.			
Date		**Interperter's Signature (if applicable)**	**Date**
4.			
Date			